

**FRAMEWORK FOR ANNUAL REPORT  
OF STATE CHILDREN'S HEALTH INSURANCE PLANS  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

**Preamble**

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- C Recognize the *diversity* of State approaches to SCHIP and allow States *flexibility* to highlight key accomplishments and progress of their SCHIP programs, **AND**
- C Provide *consistency* across States in the structure, content, and format of the report, **AND**
- C Build on data *already collected* by HCFA quarterly enrollment and expenditure reports, **AND**
- C Enhance *accessibility* of information to stakeholders on the achievements under Title XXI.

**FRAMEWORK FOR ANNUAL REPORT  
OF STATE CHILDREN'S HEALTH INSURANCE PLANS  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

State/Territory: Michigan  
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

---

(James K. Haveman, Jr.)

SCHIP Program Name (s) MIChild

SCHIP Program Type ☐ Medicaid SCHIP Expansion Only  
☐ Separate SCHIP Program Only  
☒ Combination of the above

Reporting Period Federal Fiscal Year 2000 (10/1/99-9/30/00)

Contact Person/Title Robert Stampfly, Division Director  
Managed Care Support Division

Address Capitol Commons Center,  
400 S. Pine  
P.O.Box 30037  
Lansing, MI 48909

Phone (517) 335-5121 Fax (517) 241-8969

Email stampflyb@state.mi.us

Submission Date January 5, 2001

## **Section 1. Description of Program Changes and Progress**

### **1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.**

- Program eligibility – NC
- Enrollment process – Michigan has greatly decreased the time involved in enrolling approved applicants into the MICHild/Medicaid (Healthy Kids) program. The combined MICHild/Healthy Kids application has been revised to be easier to complete and color has been added to identify and more easily locate items of importance to be completed. The application is available in English, Spanish, and Arabic.

The Administrative Contractor is consistently processing applications within ten days.

- Presumptive eligibility – NC
- Continuous eligibility – NC
- Outreach/marketing campaigns – Michigan continues to provide extensive outreach and marketing for the MICHild/Healthy Kids programs to increase enrollment and decrease the number of uninsured children in Michigan. Michigan and the United States Department of Labor met in June to discuss outreach strategies.

Outreach Incentive Payments – Effective January 2000, DCH began providing a \$25 incentive payment to local health departments (LHDs) for each person assisted with completion of a MICHild/Healthy Kids application. As of 9-22-00, LHDs have provided application assistance services to 18,927 persons and received \$473,175 in Outreach Incentive Payments.

Training – DCH continues to provide extensive training to any agency/facility/entity that requests it for MICHild/Healthy Kids. For the fiscal year, there were 64 regional and on-site trainings of approximately 538 people. In addition, there were 12 regional, joint Department of Community Health/Family Independence Agency forums, held throughout the state, that included discussion of MICHild and Healthy Kids.

Rural Health Initiatives – Outreach is targeted to the individual county through the multi-purposes collaborative bodies and LHDs. Many community-based organizations have been trained to provide application assistance for MICHild/Healthy Kids. The Executive Board of the Rural Development Council of Michigan uses a community empowerment model in developing its outreach to rural areas. Volunteers staff the Council and provide outreach and enrollment training to community groups at the community's request. With the strong support of the

Michigan USDA director, the Council trained USDA field staff to be MICHild outreach workers to the farming communities they assist. The Council focuses on training those who are already active and connected in the community and empowers them to develop and administer outreach plans with technical assistance from the Council. MICHild enrollment has increased in every community where the Council has conducted training sessions in the past year.

Tribal Outreach – Tribal Health Directors were asked to distribute MICHild and/or Healthy Kids materials at the Indian Health Centers. Eligibility workers at Federally Qualified Health Centers assisted Tribal members with the MICHild/Healthy Kids joint application.

School Outreach – Each fall, all K-12 districts are asked to distribute MICHild and/or Healthy Kids brochures to all children enrolled in the district's schools. The brochures describe the programs, encourage application, and give the toll free number to call to request an application and any needed help with completion.

Media Campaign – An extensive media campaign continues to provide information on MICHild/Healthy Kids. The media campaign includes television, radio, print, and transit posters.

Employer-Based Outreach – Beginning in May 2000, Michigan released an outreach proposal to specific employers in five counties. The proposal was targeted to businesses whose employees fit the profile and income criteria of the MICHild/Healthy Kids program. Businesses are asked to work with their employees by providing information at the workplace. This may include providing information via payroll notices, postings on employee bulletin boards, and providing applications through their payroll and personnel systems.

Michigan and the United States Department of Labor representatives met in June to discuss outreach strategies. Michigan also provides MICHild/Healthy Kids information at their Michigan Works! and Work First sites. These state agencies provide employment information and assistance to individuals who are part of the welfare system. Many times, the employers do not provide health coverage to the dependents of these individuals.

Friend of the Court Mailings – In March 2000, a pilot outreach effort was conducted in cooperation with the Muskegon County Friend of the Court (FOC) whereby those registered with the FOC were sent applications and encouraged to apply for the programs. While this pilot did not result in the response DCH had hoped, it did provide health coverage to a number of children.

Other – 1) Michigan continues to provide direct mailings to individuals, faith-based organizations, and other entities. These include brochures and/or applications. 2) DCH has had several MICHild/Healthy Kids meetings with various provider groups including the Michigan State Medical Society, the Michigan Osteopathic Association, Michigan HMOs, and the

Michigan Health and Hospital Association. These groups will assist in informing their constituents of these programs. 3) Information is also included on the Department's Web Site with instructions on how to obtain applications. This site is intended primarily for agencies, but is helpful to families who use the Internet. From 10-1-99 to 9-30-00 there were 179 applications obtained from the Web. 4) Each fall, the Administrative Contractor sends applications to those families eligible for Medicaid spend-down. Approximately 10% of families sent a mailing are subsequently found eligible for MICHild or Healthy Kids. 5) WIC families, not eligible for Medicaid, are routinely sent MICHild/Healthy Kids materials. 6) Families found eligible for Wayne County's Health Choice program for the uninsured are sent MICHild/Healthy Kids applications and are encouraged to apply. 7) MICHild/Healthy Kids applications are available in all hospital emergency rooms and in many hospital clinics. 8) MICHild information is included in all provider training.

- Eligibility determination process – Effective September 1999, Michigan revised the income budgeting process to allow proration of wage earner income among the persons in the home for whom the wage earner is fiscally responsible. This procedural change results in more equitable determinations of countable income.

Effective August 2000, Michigan implemented self-declaration of income for applicants using the DCH-0373D, MICHild/Healthy Kids combined application, which was also extensively revised for ease of completion. Previously, approximately 80% of applications had to be pended as incomplete while the applicants provided the necessary income verification. Since September 2000, only 20% of the applications are pended as incomplete. The process is now much more user-friendly and efficient. A post-eligibility audit process has been established to determine the accuracy of the self-declared income amounts.

- Eligibility redetermination process – The redetermination process has been revised effective September 2000. MICHild enrollees now receive a preprinted form listing their eligibility information on file. If there are no changes to the data on file, the cover letter is signed and returned for processing for another 12 months of coverage. Changes, if any, are indicated on the preprinted form, which is then signed and returned for eligibility determination. This revision has resulted in a more customer-friendly redetermination process, which is reflected by fewer families dropping out of the program at redetermination.
- Benefit structure - NC
- Cost-sharing policies – NC
- Crowd-out policies - NC
- Delivery system - NC

- Coordination with other programs (especially private insurance and Medicaid) - Previously, when an applicant was determined to be Healthy Kids eligible by the MICHild Contractor, the application was forwarded by US Mail to the appropriate county FIA office for processing. Upon receipt at the local FIA office, the family was assigned to a caseworker for application processing and notification of approval.

Effective August 2000, FIA staff are co-located in the offices of the Administrative Contractor. The effect of this change is that an application for anyone who appears to be Healthy Kids eligible by Administrative Contractor staff can be handed directly to FIA staff for processing on a daily basis. The co-located FIA staff receive completed applications with budgets attached, ready for review and entry into the Medicaid database. This procedural change has resulted in a seamless processing of applications. Any questions or issues can be resolved at the time the file is transferred to the FIA staff. The applicants are notified of approval a minimum of two to three weeks sooner than was possible under the former processing and referral system.

In addition, DCH runs a quarterly tape match between MICHild and Healthy Kids. If the child is also enrolled in Healthy Kids, he/she is disenrolled from MICHild, effective the first day of the following month.

- Screen and enroll process - NC
- Application – The application has been extensively revised into a more user-friendly format. While the application length remains at two double-sided pages, colors have been added to define the different portions of the application, with the most critical instructions highlighted in yellow.
- Other – NC

## 1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

- **Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.** In October 1999, there were 23,146 sixteen to eighteen year olds enrolled in the Healthy Kids Medicaid Expansion. In September 2000, there was an increase to 26,574 in this same age group, an increase of 3,428 children, or 15%. In October 1999, there were 11,701 children enrolled in MICHild, which increased to 15,006 for September 2000. This is an increase of 3,305 children, or 28%. These numbers are from the actual count of active enrollees in each program.
- **How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to**

**derive this information.** There were 266,985 children enrolled in Healthy Kids in September 2000. This is a 9% increase in the number of Medicaid enrollees. These numbers are derived from the CIS data system. We cannot attribute all of these enrollments solely to the SCHIP outreach activities and enrollment simplification; however, we are sure that these efforts have helped.

- **Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State. NC**
- **Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?**

  X   No, skip to 1.3

       Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

### **1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).**

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- |           |   |
|-----------|---|
| Column 1: | List your State's strategic objectives for your SCHIP program, as specified in your State Plan.   |
| Column 2: | List the performance goals for each strategic objective.  |
| Column 3: | For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please |

attach additional narrative if necessary.

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
<b>OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN</b>		
1. To increase the number of low-income children in Michigan with creditable health insurance coverage by means of moving children under age 19 without health insurance into either accessible, quality Medicaid or MICHild coverage while not simultaneously crowding out private coverage	Goal 1: Enroll the estimated number of uninsured, low-income children in Michigan in either the Medicaid program or the MICHild program, as appropriate.	<p>Data Sources: For numerator, MICHild enrollment file and count of MICHild/Healthy Kids common applications processed; for denominator, number of uninsured children under age 19 based on the Urban Institute's National Survey of American Families.</p> <p>Methodology: Count number of MICHild applicants enrolled through 9/2000 (15,006); count estimated number of Healthy Kids enrollees based on number of applications found likely to represent Medicaid eligibles at initial eligibility screening x 1.8 children per application (<math>46,835 \times 1.8 = 83,043</math>).</p> <p>Numerator: MICHild enrollees as of 9/30/2000 (15,006) + HK enrollees added since beginning of SCHIP program (83,043) = 98,049.</p> <p>Denominator: 106,000 children under age 19 whose family income is at or below 200% of FPL.</p> <p>Progress Summary: <math>98,049/106,000 = 92</math> percent of potentially eligible children are now insured. Increase in enrollment during FY 2000 = <math>98,049 - 72,042 = 26,007</math> or 36 percent increase during FY 2000.</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
<b>OBJECTIVES RELATED TO SCHIP ENROLLMENT</b>		
	Goal 2: Enroll in the MICHild program 100% of eligible children who participate in the Caring Program for Children	N/C  Progress Summary: 100% of Caring Program for Children were enrolled into MICHild as of October 1998. These children were then considered MICHild enrollees and proceeded through fiscal year 2000 according to MICHild eligibility and redetermination processes.
<b>OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT</b>		
	Goal 3: Local agencies and programs will contact low-income families representing 106,000 uninsured children and make known to the families the availability of Medicaid and MICHild health coverage.	Data Sources: Reports of local agencies under contract to the Department during CY 2000.  Methodology: Total counts of outreach contacts made by contracted agencies based on incentive payment reporting.  Contacts Made: Applications submitted for 17,252 children who appeared to be eligible for either MICHild or Healthy Kids.  Progress Summary: The extent of agencies' efforts was even more far-reaching than the statistics alone indicate. The number of children enrolled in MICHild/Healthy Kids

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		suggests this goal continues to be substantially met.
<b>OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)</b>		
	<p>Goal 4: Obtain accurate usable HEDIS® reports from MICHild providers and monitor the following outcomes with emphasis on:</p> <ul style="list-style-type: none"> <li>a. well-child exams</li> <li>b. immunizations</li> <li>c. receipt of at least one physician visit per MICHild enrollee annually.</li> <li>d. Receipt of at least one dental exam per MICHild enrollee annually</li> </ul>	<p>Michigan believes that the quality studies performed during the year demonstrate our progress towards monitoring MICHild access and quality outcomes. Although Goal 4 is measured with HEDIS®-Like Reports, we have included the 2000 CAHPS® 2.0H Surveys and other satisfaction surveys which evaluate the satisfaction of the MICHild members with their MICHild benefits.</p> <p><b>HEDIS®-Like Reports</b></p> <p>Data Sources: Blue Cross Blue Shield of Michigan (BCBSM) HEDIS®-like data reports for Measurement Year 1999. HMOs did not meet the 1,000 continuous enrollment numbers necessary for HEDIS®.</p> <p>Methodology: Standard HEDIS® methodology applied to HEDIS®-like reports. BCBSM pulled all facility, pharmacy, and professional claims incurred in 1999 for these continuously enrolled MICHild members. Summary data was produced for use of services, access, and cost reporting and to determine which effectiveness of care measures were feasible.</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<p>Numerator and Denominator (Sample): All MICHild members (group 31295) were identified from the BCBSM membership files. All members included in HEDIS® measures were verified for continuous enrollment. The total MICHild health enrollment on January 1, 1999 was 5,156. By January 1, 2000 enrollment was 10,400, but only 2,674 members met HEDIS® continuous enrollment criteria for the measurement year.</p> <p>HEDIS®-like Data Report Progress Summary: BCBSM 2000 HEDIS®-like data measures are slightly different from the measures identified in the MICHild State Plan, because HEDIS® measures changed from 1998 to 1999. BCBSM's findings are as follows:</p> <p>Effectiveness of Care Measure:</p> <p>Childhood Immunization/Adolescent Immunization. Rates are not presented, because BCBSM does not pay a significant volume of claims for childhood immunizations to make valid conclusions regarding the utilization. BCBSM has taken steps to improve immunization rates. Post Card reminders were mailed to all MICHild members in October and November.</p> <p>Access and Availability of Care Measure:</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<p>Children's Access to Primary Care Providers. Eighty-six percent of children 12 to 24 months, eighty percent of children 25 months to 6 years, and seventy-two percent of children 7 to 11 years received a visit with a primary care provider.</p> <p>Initiation of Prenatal Care. Only four live deliveries to MICHild members.</p> <p>Annual Dental Visit. Sixty-one percent between ages 4 and 19 had at least one claim for a dental visit.</p> <p>Use of Services Measure:</p> <p>Well-Child Visits in the First 15 Months of Life. No members met HEDIS® specifications for this measure.</p> <p>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life. Thirty-six percent of the children had at least one comprehensive well-care visit in 1999.</p> <p>Adolescent Well-Care Visits. Fourteen percent of enrollees between the ages of 12</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<p>and 19 had at least one comprehensive well-care visit in 1999.</p> <p>Myringotomy is the most frequently performed procedure with 2.1 procedures per 1000 member months.</p> <p>Outpatient Drug Utilization: The average number of prescriptions per year is 4.4 for children ages 0-9. The average number of prescriptions per year is 5.1 for children ages 10-19.</p> <p><b>Other BCBSM Quality Studies:</b></p> <p>Antibiotic use for Viral Infections. Seventy-five percent of BCBSM commercial-enrolled children are prescribed antibiotics for colds, Upper Respiratory Infections, or bronchitis as compared to eighty-eight percent of MICHild enrollees.</p> <p><b>2000 CAHPS™ 2.0H Member Satisfaction Surveys were conducted by BCBSM and Market Facts:</b></p> <p>Data Sources: BCBSM 2000 CAHPS™ 2.0H Member Satisfaction Survey was</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<p>conducted by MORPACE International, A National Committee on Quality Assurance (NCQA) certified survey research provider.</p> <p>Methodology: The BCBSM CAHPS™ 2.0H survey focused on the 12-month period prior to the administration of the survey. This corresponds to the 1999 NCQA Quality compass reporting year of January 1, 1999 to December 31, 1999. The questions, their placement in the survey tool, and the response options, the mailing and telephone methodology are mandated by NCQA. Data selection was a stratified random sampling. In March of 2000, 850 BCBSM members were selected with results for 369 respondents. Response rate was 68 percent.</p> <p>Numerator and Denominator (Sample): All MICHild members who were eligible were included in the population from which survey members were selected. Eligible members are defined as members who are covered by BCBSM MICHild Health Plan. Members must be 12 years or younger as of December 31 of the measurement year and must have been continuously enrolled for the HEDIS® reporting year. Continuous enrollment allows for one coverage lapse of up to 45 days during the reporting year.</p> <p>BCBSM 2000 CAHPS™ 2.0H Progress Summary:</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<p>Eighty-nine percent of respondents felt that getting care that was needed was not a problem. Eighty-nine percent of respondents felt that they usually/always could get care quickly. Ninety-four percent of respondents were usually/always satisfied with provider communication and the courteous office staff (composite measures).</p> <p>Eighty-seven percent of respondents rate the experience with the child's health plan as 8, 9, or 10. Eighty-one percent of respondents rate their experience with their child's doctor or nurse as 8, 9, or 10. Eighty-four percent rate the specialist seen the most often by their child as 8, 9, or 10 (overall rating measure).</p> <p>Data Sources: Market Facts 2000 CAHPS™ 2.0H Survey</p> <p>Methodology: CAHPS™ 2.0H survey is considered valid and reliable when obtained from a period of twelve consecutive months of managed care enrollment for the enrollee studied.</p> <p>Numerator and Denominator (Sample): The child identified must be MICHild eligible for 5 of last 6 months of calendar year 1999. Child identified must be MICHild eligible as of May 2000.</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<p>Market Facts 2000 CAHPS™ 2.0H Survey Progress Summary: Market Facts' raw data for fiscal year 2000 has been analyzed and evaluated for this report. The initial result of the September 2000 CAHPS™, with 61 percent response rate, shows that 50 percent of respondents rate their MICHild health provider as the “best possible.” Additionally, 39 percent of respondents rate their MICHild provider as 8 or 9 of a possible score of 10. Eighty-five percent of MICHild enrollees received regular, routine medical care in the previous 12 months, and 21 percent of these children were seen the same day a call was made to request an appointment for routine care.</p> <p>Data Source: December 2000 MICHild Satisfaction Survey Administrative Contractor (Maximus) in November 2000.</p> <p>Methodology: This is the second annual MICHild Satisfaction Survey administered by the Administrative Contractor. Three hundred MICHild families were chosen at random. Sixteen-to-eighteen year-olds, who are State Children’s Health Insurance Program eligible, receiving services through Healthy Kids were not subject to being interviewed.</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<p>Numerator and Denominator (Sample): All of the families surveyed received MICHild benefits for at least six months prior to the interview and were active in December. There were approximately 450 children in the households interviewed.</p> <p>December 2000 MICHild Satisfaction Survey Progress Summary: Nearly ninety-five percent of the families have seen a doctor, and over three quarters of the families have seen a dentist. Over half of the families took their child to the doctor for well-child checkups or immunizations. A small percentage of families utilized mental health or substance abuse services. Those families that received these services indicated the service was good to excellent.</p> <p><b>Dental Satisfaction Survey was conducted by BCBSM. Delta Dental Plans and the Department of Community Health are preparing to administer other dental satisfaction surveys:</b></p> <p>Data Sources: July 2000 BCBSM Dental Satisfaction Survey</p> <p>Methodology: The survey was prepared in-house at BCBSM with the assistance of the corporate survey coordination department. The survey instrument was limited to a one-page survey form. The dental survey was conducted during the period from June</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<p>23-July 21, 2000. The survey was mailed to the MICHild families and follow-up post cards were sent two weeks later. It was limited to families who did not receive the BCBSM CAHPS survey. The survey response rate was 19.4 percent (120 families). BCBSM commercial response is comparable at 20 percent.</p> <p>Numerator and Denominator (Sample): All families whose children have only dental coverage through BCBSM and have been enrolled for at least 6 months. An additional 200 families from among those with both health and dental coverage who have been enrolled for at least 6 months and who have children aged 13 and older. It is possible that a family with children both over 12 and under 12 could receive both surveys using this approach. BCBSM sampled 620 MICHild dental families.</p> <p>July 2000 BCBSM Dental Satisfaction Survey Progress Summary: Overall satisfaction with the dentist was 94 percent. Overall satisfaction with the hygienist was 96 percent. MICHild members were very satisfied with the cleanliness (95%), time spent in the waiting room (95%), and most members were satisfied with the length of time needed to make an appointment (84%).</p> <p>Data Source: 2000 Delta Dental Plans MICHild Premier and Preferred plans.</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<p>Methodology: Delta Dental has a survey developed in-house for its commercial enrollees that it will administer as a MICHild specific dental satisfaction survey.</p> <p>Numerator and Denominator (Sample): Delta plans to administer the commercial survey to all 5,600 MICHild enrollees.</p> <p>2000 Delta Satisfaction Survey Progress Summary: The Premier and Preferred Satisfaction Survey is in progress. It was delayed due to the replacement of the scanner/tabulator.</p> <p>Data Source: Michigan anticipates that its Dental Satisfaction Survey will be administered by Market Facts.</p> <p>Methodology: The Market Facts Dental Satisfaction Survey tool is being prepared in collaboration with the Department of Community Health. The survey will be administered in the Spring of 2001. The same survey tool will be sent to three groups which are the MICHild BCBSM and Delta enrollees and Healthy Kids dental enrollees. At this time, the plan is to contract with Market Facts for two mailings and a phone follow-up.</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<p>Numerator and Denominator (Sample): The Market Facts Dental Satisfaction Survey sample is in the planning stage. Discussions for a sample are a random sample of 1500 eligibles from each group. The Administrative Contractor will generate the file with the eligibles. We are anticipating 400-500 response from each group.</p> <p>Market Facts Dental Satisfaction Survey Progress Summary: NC</p>

<b>OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)</b>		
	See Goal 3.	<p>BCBSM Quality Improvement Measures</p> <ul style="list-style-type: none"> <li>• Post card reminders encouraging families to bring their child's immunizations up to date.</li> <li>• Post card reminders encouraging families to schedule their child's well-baby and well-child exams.</li> <li>• BCBSM MICHild families sent the book <i>Taking Care of Your Child</i>.</li> <li>• BCBSM MICHild families are eligible for a Blue Healthline program which provides access to RNs 24 hours per day, seven days a week.</li> </ul>

		<ul style="list-style-type: none"> <li>All families receive <i>Living Healthy</i>, a magazine published twice a year with articles on common childhood issues, e.g. bicycle safety, asthma.</li> </ul>
<b>OTHER OBJECTIVES</b>		
	Goal 5: Provide an application and enrollment process that is easy for families to understand and use.	<p>Data Sources: Administrative Contractor Satisfaction Survey, Weekly/Monthly reports from the Administrative Contractor</p> <p>Methodology: Satisfaction Survey: Random sample of MICHild families were asked whether the enrollment and eligibility determination process was easy.</p> <p>December 2000 MICHild Satisfaction Survey Progress Summary: Actual monthly number of application submitted using the MICHild/Healthy Kids combined application. Actual numbers of follow-up letters and calls made regarding incomplete applications. Nearly three-quarters of the MICHild households continue to rate the application process as good to excellent; while another 21 percent rated the process as average.</p> <p>Weekly/Monthly Reports from the Administrative Contractor Progress Summary: Previously the rate of incomplete applications was 80 percent, primarily due to delays in providing income verification. Subsequently, the rate of incomplete applications is now 20 percent. Further, the number of applications submitted monthly has increased from an average of 2,300 for September and October 1999 to an average of 4,000 for September and October 2000.</p>
	Goal 6: Obtain participation of community-based organizations in outreach and education activities	<p>Data Sources: LHDs, multi-purpose collaborative bodies, MSA Local Services Section, Training Unit, Administrative Contractor, MSA's Education and Outreach Section</p> <p>Methodology: Number and amount of outreach incentive payments for the fiscal year;</p>

		<p>informal reports from the multi-purpose collaborative bodies; number and types of trainings requested; number, types, and, origin of requests for information from the Administrative Contractor; reports from the Education and Outreach Section</p> <p>Progress Summary: 100% of the LHDs participate in the outreach incentive payments; approximately 75 trainings were held by the Training Unit; Education and Outreach Section held numerous sessions throughout the state, there was a presenter at every Michigan Works! And Work First site throughout the state to provide information on MICHild and Healthy Kids.</p>
--	--	---



**1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them. N/C**

HMO HEDIS® reports were not requested due to less than 1,000 enrollees during reporting year. BCBSM encountered barriers in its HEDIS® report. Some of the data was not available in 1999 and is will be collected by BCBSM for 2000. In other situations measures were not performed due to the small number of beneficiaries for selected measures. BCBSM believes that children are receiving required immunizations from other sources, such as county health departments and health fairs. Next year, BCBSM plans to access data in the Michigan Immunization Register.

**1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives. N/C**

**1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.** The Market Facts 2000 CAHPS™ 2.0H Survey results should be available soon. Preliminary findings are reported in Table 1.3. It is anticipated that the Market Facts Dental Satisfaction Survey will be administered in Spring 2001.

**1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.**

Administrative Contractor's December 2000 Satisfaction Survey  
MarketFacts CAHPS™ 2.0H Survey Tool  
BCBSM 2000 HEDIS® and 2000 CAHPS™ 2.0H Reports  
BCBSM Dental Satisfaction Survey Report  
Delta Dental Plans Satisfaction Survey Tool  
Executive Summary  
Outreach Reports

## SECTION 2. AREAS OF SPECIAL INTEREST

---

*This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.*

### 2.1 Family coverage: N/A

- A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.
2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

Number of adults \_\_\_\_\_

Number of children \_\_\_\_\_

3. How do you monitor cost-effectiveness of family coverage?

### 2.2 Employer-sponsored insurance buy-in: N/A

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).
2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

Number of adults \_\_\_\_\_

Number of children \_\_\_\_\_

### 2.3 Crowd-out:

#### A. How do you define crowd-out in your SCHIP program?

Crowd-out is when a family voluntarily drops employer-sponsored dependent health coverage and enrolls their children in MICHild.

- B. **How do you monitor and measure whether crowd-out is occurring?** During the application process, applicants are asked if the children have other insurance through the employment of a parent. If the children are covered, or have had employer-sponsored health coverage in the preceding 6 months, the children are not eligible for MICHild. Exceptions are granted when the coverage was lost through no fault of the family ( e.g., employer dropped dependent coverage, family member lost job) or in cases where coverage is not accessible (e.g., coverage provided by a

non-custodial parent is an HMO whose coverage area does not include the child's home). Employer coverage does not preclude MICHild enrollment if it does not meet the state's definition of comprehensive coverage.

Occasionally, a contracted HMO may indicate that a child has other insurance at the time of application which the family failed to disclose. In most of the cases, it was determined that the dual coverage occurred after MICHild enrollment, which is permissible per our policy.

- C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation. Overall, crowd-out does not appear to be a problem.
- D. **Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.** This is a moot point for Michigan as we have just the one policy on crowd-out.

## 2.4 Outreach:

- A. **What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?** The most effective outreach mechanism has been the combined MICHild/Healthy Kids media campaign implemented by the state. Broadcast media tops the list of the most frequently cited source of information in every survey of MICHild applicants. The state's media campaign is targeted to MICHild-eligible families and is run statewide.
- B. **Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?** The rural initiative described in 1.1 has been very successful.
- C. **Which methods best reached which populations? How have you measured effectiveness?**

## 2.5 Retention:

1. **What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?** Michigan has adopted an easier method for redeterminations. This is discussed under 1.1.
2. **What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?**  
\_\_\_\_ Follow-up by caseworkers/outreach workers  
X Renewal reminder notices to all families

- ☐ Targeted mailing to selected populations, specify population \_\_\_\_\_
- ☐ Information campaigns
- ☒ Simplification of re-enrollment process, please describe **See 1.1** \_\_\_\_\_
- ☒ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe.

**The Administrative Contractor conducts monthly telephone surveys of a subset of the population who failed to renew their MICHild enrollment.** The primary reason given by respondents is that the children are now covered by other insurance.

☐ Other, please explain \_\_\_\_\_

3. **Are the same measures being used in Medicaid as well? If not, please describe the differences.** The same measures are not used in Medicaid. Medicaid does not use the simplified redetermination form and no telephone survey is conducted. For Medicaid redeterminations, a new application is sent to the family annually. Due to the volume of applications/redeterminations that FIA must handle every month for welfare programs and Medicaid, it is not feasible to follow-up on each disenrollment from Healthy Kids.
4. **Which measures have you found to be most effective at ensuring that eligible children stay enrolled?** The simplified redetermination form has been most effective in ensuring that children stay enrolled in MICHild. This is verified by the increased number of children who remain on MICHild each month since the new process was implemented.
5. **What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured)? Describe the data source and method used to derive this information.** The monthly telephone survey conducted by the Administrative Contractor (discussed in 2.5.2) provides information on a sampling of disenrolled children who have obtained other health coverage. The reason cited by the vast majority of families who do not re-enroll children in the MICHild program is that the children are now covered through employer-based coverage.

## **2.6 Coordination between SCHIP and Medicaid:**

**Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.**

The same application is used for MICHild and Healthy Kids. If the combined application is used (DCH-0373D), then the same verification requirements are used. There is no interview requirement for MICHild or Healthy Kids. If the family applies for coverage for the children using the FIA-1171 (used for all Medicaid and welfare programs), then verification of income is required. DCH is currently working with FIA regarding verification of income for Healthy Kids who apply for benefits using the FIA-1171.

The redetermination process is different. As discussed previously, the MICHild redetermination form is a preprint of the information currently on file for the family. If the information has changed, the family notes that on the form, signs it and returns it to the Administrative Contractor. For Healthy Kids, the family must complete a new application and return it to the county FIA office.

**Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.** If a MICHild enrollee at redetermination appears to be eligible for Healthy Kids, the application is hand-carried to the co-located FIA staff.

If the child is already Healthy Kids eligible, the application and budget are sent to the Administrative Contractor with a notation of when the Healthy Kids coverage will end. These applications are reviewed on a priority basis to ensure continuity of coverage between the two programs.

Both the Administrative Contractor and FIA have been instructed to accept the other agency's budget. This will allow for seamless coverage and resolves the issue of "bouncing" between agencies as a result of possible misinterpretation of policy between the programs.

**Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.** The delivery systems for MICHild and Healthy Kids are not identical – although there is some overlap among HMOs serving both programs. The MICHild plan selected by eighty percent of the families is Blue Cross and Blue Shield of Michigan (BCBSM). BCBSM does not participate in the Medicaid program. Even though BCBSM does not participate in Medicaid, many of the enrolled providers do participate. This fact makes it relatively easy for families to find a health plan in either MICHild or Medicaid that includes the children's doctor.

## **2.7 Cost Sharing:**

- 1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?** Michigan's only form of cost sharing in the MICHild program is a \$5 per family monthly premium. The monthly telephone survey conducted by the Administrative Contractor does ask if the amount of the premium was responsible for the child's disenrollment from MICHild. The results of the survey have not shown this to be a factor in disenrollment.
- 2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?** Michigan does not impose cost sharing in the form of copayments.

## **2.8 Assessment and Monitoring of Quality of Care:**

- 1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.**

Quality of Care: HEDIS®-Like Report for measurement year 1999. HMOs did not submit HEDIS® reports. See Table 1.3, Goal 3 for a summary of results.

Other BCBSM Quality Studies included in the HEDIS®-like report. See Table 1.3, Goal 3 for a summary of results.

2000 CAHPS™ 2.0H Member Satisfaction Surveys by BCBSM, Market Facts, and Administrative Contractor. See Table 1.3, Goal 3 for a summary of the survey results.

Dental Satisfaction Surveys by BCBSM, Delta Dental, and Market Facts. See Table 1.3, Goal 3 for a summary of the survey results.

Complaints and Grievances are logged for the 1<sup>st</sup> and 2<sup>nd</sup> quarters fiscal year 2001. No complaints or grievances were reported by the health plans.

Dental utilization data by BCBSM and Delta Dental.

BCBSM utilization for services October 1, 1998-December 31, 1999. The percentage of members receiving at least one dental service was approximately seventy-four percent.

Delta Dental Plans utilization data for services in 1999: Premier percentage of members receiving at least one dental service was seventy-six percent. Preferred percentage of members receiving at least one dental service was fifty-five percent.

**2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?**

See Table 1.3, Goal 3. Michigan utilized the HEDIS®-like reports to monitor and assess the well-baby care, well-child care, and immunizations provided by the BCBSM network. This was a first effort by BCBSM to take paid claims data from the PPO network and produce summary data for use of services, access, and cost reporting and to determine which effectiveness of care measures were feasible. Since HMOs did not perform HEDIS®, MICHild consumers can not compare the results with BCBSM. Additionally, Michigan believes that valid conclusions regarding the utilization of preventive services can not be drawn from the findings of the report. Some of the data was not available in 1999 and is being collected by BCBSM for the calendar year 2000. In other situations, measures were not performed due to the small number of beneficiaries for selected measures. Instead, we believe that the well-baby care, well-child care, and immunization measures that are

reported in the three Consumer Satisfaction Survey performed this year are a better means to monitor and assess quality of preventive care received by MICHild enrollees.

Mental health and substance abuse counseling and treatment are monitored through the December 2000 MICHild Satisfaction Survey administered by the Administrative Contractor and the complaint and grievance process. See Table 1.3, Goal 3 for the Satisfaction Survey results. A process has been implemented with the Administrative Contractor and the Department of Community Health in which questions or complaints and grievances can be directed to one of the area managers for Consumer & Community Issues in the Community Mental Health Contract Management section. A log of the mental health and substance abuse complaints and grievances is maintained.

Dental care is monitored through the BCBSM dental utilization data submitted April 2000, BCBSM 2000 CAHPS™ 2.0H Survey, the December 2000 MICHild Satisfaction Survey administered by the Administrative Contractor, and July 2000 BCBSM Dental Satisfaction Survey. The 2000 Delta Dental Plans Satisfaction Survey and the Market Facts Dental Satisfaction Survey results are unavailable.

Vision care is measured by utilization data. Michigan has not requested vision paid claim data from BCBSM or the HMOs.

3. **What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?** DCH is planning on continuing the existing surveys, as noted in #1, on an annual basis.

### **SECTION 3.   SUCCESES AND BARRIERS**

---

**3.1 Please highlight successes and barriers you encountered during FY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.**

1. Eligibility - N/A
2. Outreach - One very successful initiative was the \$25 outreach incentive payment, as noted in 1.1. Michigan is also very pleased with the outreach efforts to employers through Michigan Works! and Work First.  
  
One of the barriers to using other programs for outreach, such as WIC or Friend of the Court is the inaccuracy of addresses due to the mobility of these populations..
3. Enrollment - One successful initiative is the self-verification of income. Prior to this, only 20% of applications were considered complete as income verification was not included. Now, 80% of the applications are complete (with lack of choice of a health plan as the main reason for not being complete).
4. Retention/disenrollment - The new redetermination form has proven to be very successful in retaining enrollment in MICHild.
5. Benefit structure - N/A
6. Cost-sharing - N/A
7. Delivery systems - N/A
8. Coordination with other programs - The co-location of FIA staff at the Administrative Contractor's office has been very successful in the coordination of programs. The ability to immediately enroll a child in Healthy Kids has been an asset to both FIA and DCH.
9. Crowd-out - N/A
10. Other – N/A

## SECTION 4. PROGRAM FINANCING

**4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.**

*Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).*

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
<b>Benefit Costs</b>			
Insurance payments			
Managed care			
per member/per month rate X # of eligibles	38,213,953	44,421,554	48,449,183
Fee for Service	8,685,896	9,352,846	9,914,017
Total Benefit Costs	46,904,849	53,774,400	58,363,200
(Offsetting beneficiary cost sharing payments)	(489,113)	(645,315)	(733,495)
Net Benefit Costs	46,415,736	53,129,085	57,629,705
<b>Administration Costs</b>			
Personnel	0	0	0
General administration	2,563	3,000	3,000
Contractors/Brokers (e.g., enrollment contractors)	2,627,269	3,098,860	3,098,860
Claims Processing	0	0	0
Outreach/marketing costs	0	2,801,372	3,301,441
Other	0	0	0
Total Administration Costs	2,629,862	5,903,232	6,403,301
10% Administrative Cost Ceiling	5,157,304	5,903,232	6,403,301
Federal Share (multiplied by enhanced FMAP rate)	33,635,471	40,927,105	44,470,922
State Share	15,410,127	18,105,211	19,562,083
<b>TOTAL PROGRAM COSTS</b>	<b>49,045,597</b>	<b>59,032,316</b>	<b>64,033,005</b>

**4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000. N/A**

**4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?**

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations (such as United Way, sponsorship)
- ☒ Other (specify) Premium payments by the families \_\_\_\_\_

**A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures. No**

## SECTION 5: SCHIP PROGRAM AT-A-GLANCE

**5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information.** If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
<b>Program Name</b>	Healthy Kids	MIChild
<b>Provides presumptive eligibility for children</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? Any child under 19 for 2 months (at that point, the Administrative Contractor and the state should verify eligibility), but no plan has implemented this option.
<b>Provides retroactive eligibility</b>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? Children under age 19 for up to 3 months	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
<b>Makes eligibility determination</b>	<input checked="" type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other ( <i>specify</i> ) _____	<input checked="" type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other ( <i>specify</i> ) _____
<b>Average length of stay on program</b>	Specify months <u>N/A</u>	Specify months <u>4.48 months</u>
<b>Has joint application for Medicaid and SCHIP</b>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
<b>Has a mail-in application</b>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes

<b>Table 5.1</b>	<b>Medicaid Expansion SCHIP program</b>	<b>Separate SCHIP program</b>
<b>Can apply for program over phone</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
<b>Can apply for program over internet</b> (An application can be downloaded and mailed)	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
<b>Requires face-to-face interview during initial application</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
<b>Requires child to be uninsured for a minimum amount of time prior to enrollment</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ What exemptions do you provide?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>6</u> _____ What exemptions do you provide? This only applies to employer-based insurance coverage.
<b>Provides period of continuous coverage <u>regardless of income changes</u></b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>12</u> _____ Explain circumstances when a child would lose eligibility during the time period Only for nonpayment of premiums and eligible for Medicaid, or reach age 19, or move out of state.
<b>Imposes premiums or enrollment fees</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, how much? _____ Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify) _____ —	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, how much? <u>\$5.00/month/family</u> Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify) <u>Anyone as long as identify the family that is it for</u>
<b>Imposes copayments or</b>	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
coinsurance	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Provides preprinted redetermination process	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information precompleted and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, we send out form to family with their information and: <input checked="" type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed

**5.2 Please explain how the redetermination process differs from the initial application process.**

For MICHild, the application is the DCH-0373D. It is a 2-page (front and back) application. At redetermination, the family is sent a preprinted redetermination form that they confirm or change information on. The eligibility determination process is the same for both application and redetermination.

For Healthy Kids, the application is either the DCH-0373 or FIA 1171. As noted above the DCH-0373 is a 2-page application. The FIA-1171 is a 9-page (front and back) form for all categories of Medicaid and welfare programs. At redetermination, a new application is required. The eligibility determination process is the same for both application and redetermination.

## SECTION 6: INCOME ELIGIBILITY

---

**6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group?** If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or  
Section 1931-whichever category is higher

185 % of FPL for children under age 1  
150 % of FPL for children aged 1 to 19  
\_\_\_\_ % of FPL for children aged \_\_\_\_\_

Medicaid SCHIP Expansion

150 % of FPL for children aged 16 to 19  
\_\_\_\_ % of FPL for children aged \_\_\_\_\_  
\_\_\_\_ % of FPL for children aged \_\_\_\_\_

State-Designed SCHIP Program

200 % of FPL for children aged 0 to 19  
\_\_\_\_ % of FPL for children aged \_\_\_\_\_  
\_\_\_\_ % of FPL for children aged \_\_\_\_\_

**6.2 As of September 30, 2000, what types and amounts of disregards and deductions does each program use to arrive at total countable income?** *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.* @

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)   X   Yes        No

If yes, please report rules for applicants (initial enrollment).

<b>Table 6.2</b>			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	\$90	\$90	\$90
Self-employment expenses	\$As verified	\$As verified	\$As declared
Alimony payments Received	\$N/A	\$N/A	\$N/A
Paid	\$N/A	\$N/A	\$N/A
Child support payments Received	\$50	\$50	\$50
Paid	\$As verified	\$As verified	\$As declared
Child care expenses	\$200 per child	\$200 per child	\$200 per child
Medical care expenses	\$ N/A	\$ N/A	\$ N/A
Gifts	\$ N/A	\$ N/A	\$ N/A
Other types of disregards/deductions (specify) \$30 + 1/3 of the earned income if the person has received FIP/LIF in 1 of the 4 calendar months preceding the month being tested	\$30 + 1/3	\$30 + 1/3	\$ N/A

**6.3 For each program, do you use an asset test?**

Title XIX Poverty-related Groups ☒ No ☐ Yes, specify countable or allowable level of asset test\_\_\_\_\_

Medicaid SCHIP Expansion program ☒ No ☐ Yes, specify countable or allowable level of asset test\_\_\_\_\_

State-Designed SCHIP program ☒ No ☐ Yes, specify countable or allowable level of asset test\_\_\_\_\_

Other SCHIP program\_\_\_\_\_ ☒ No ☐ Yes, specify countable or allowable level of asset test\_\_\_\_\_

**6.4 Have any of the eligibility rules changed since September 30, 2000?** ☐ Yes ☒ No

**SECTION 7: FUTURE PROGRAM CHANGES**

---

**7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001( 10/1/00 through 9/30/01)?** Please comment on why the changes are planned.

1. Family coverage – The state continues to review this option.
2. Employer sponsored insurance buy-in – The state continues to review this option.
3. 1115 waiver – N/A
4. Eligibility including presumptive and continuous eligibility – Michigan has already implemented these options
5. Outreach – Michigan has several future initiatives for outreach. 1) Identify what is being done by community outreach to small businesses and the Chambers of Commerce. 2) Pursue the school lunch programs with the Michigan Department of Education. Pursue with school counselors, nurses, and principals as to their best practices and contact their state associations for assistance. 3) Work with the following state agencies on outreach: Consumer and Industry Services, Division of Child Day Care Licensing, Michigan Women’s Commission, WIC, Michigan Center for Rural Health, Watch Me Grow calendars to promote MICHild and Healthy Kids, Early On Managed Care subcommittees.
6. Enrollment/redetermination process – work with FIA to streamline the eligibility/enrollment process for Healthy Kids, regardless of the application form used.
7. Contracting – N/A

8. Other – N/A